BARS AND CIVIC ORGANIZATION REQUIREMENTS

Reason for Application (please circle):

New Facility **Change of Ownership** **Changes to Facility**

This sheet must be completed for all new bars and civic organizations. If this is a change of ownership, you must also complete this form but you will be held to the plumbing code at the original time of permitting until the facility is expanded or changes use.

DATE:_____ **PROPOSED # OF SEATS:_____** **PROPOSED # OF STAFF:_____**

PROJECT NAME:_____

ADDRESS:_____

PERSON TO CONTACT:_____ **PHONE:**_____

EMAIL ADDRESS:_____

Waste Water

- ☐ **Water bill showing waste water charges or letter of sewer connection provided OR**
- ☐ **Facility is on septic. Must fill out Existing System Verification OR modify existing annual operating permit if applicable.**

Water supply ☐ **public water OR** ☐ **well**

- ☐ **Plan Review fee, Annual Permit fee and ABT sign-off fee paid**
- ☐ **Floor plans of facility provided and drawn to scale. Scale must be shown on the floor plan.**
- ☐ **1 toilet shown on floor plan for every 40 patrons.**
- ☐ **Must show both men's and women's restrooms on floor plan.**
- ☐ **1 hand wash sink shown on floor plan for every 75 patrons in each restroom.**
- ☐ **At least 1 hand wash sink in each bar area. Also needed in kitchen area for civic organizations.**
- ☐ **At least 1 3-compartment sink shown on floor plan (if applicable).**
- ☐ **1 mop sink shown on floor plan.**

____ **Number of pool tables /** ____ **video games.**

Y / N **Is this a civic organization that prepares food? Please keep in mind that food preparation is not permitted in bar facilities. Bars are permitted to serve prepackaged food and "bar" type food only.**

_____ _____

Signature, Owner / Owner's Representative Date Rev 01222015

ORANGE COUNTY HEALTH DEPARTMENT PLANS REVIEW ROUTING SHEET

DATE:_____ **PLANS ROUTING NUMBER:**_____

PAYMENT TYPE:_____ **AMOUNT:**_____ **CHECK NUMBER:**_____

Please note, the fee for plan review is $48 per hour. If your plan review requires additional time or requires revisions, you will be charged an additional $48 per hour before approval. Please sign below to acknowledge your understanding and acceptance of these conditions. By signing below, you are also certifying that the information provided is true and correct.

SIGNATURE:_____ **DATE:**_____

FACILITY NAME:_____

FACILITY ADDRESS:_____

BILLING ADDRESS:_____

TYPE OF FACILITY:_____ **NUMBER OF EMPLOYEES:**_____

NUMBER OF CLIENTS, STUDENTS, CUSTOMERS OR SEATING CAPACITY:_____

METHOD OF SEWAGE DISPOSAL:_____ **WATER SUPPLY:**_____

PERSON TO CONTACT:_____ **PHONE #:**_____

FOR OFFICE USE ONLY

UTILITY REVIEWER:_____ **DATE:**_____

REMARKS:_____ **APPROVAL STAMP**

_____

_____

_____

SIGNATURE:_____

FACILITY REVIEWER:_____ **DATE:**_____

REMARKS:_____

_____

_____

_____

SIGNATURE:_____

Florida Department of Health in Orange County
Division of **Division of Disease Control and Health Protection**
Bureau of Environmental Health
1001 Executive Center Drive Suite 200, Orlando, FL 32803
PHONE: 407 858 1497 • FAX 407 228 1467
http://orange.floridahealth.gov/

www.FloridasHealth.com
TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh

Certificate Number

STATE OF FLORIDA
DEPARTMENT OF HEALTH

APPLICATION FOR A SANITATION CERTIFICATE

AUTHORITY: Chapter 381, Florida Statue

Instructions: 1. Provide the remainder of the information requested below. 2. If any of the pre-completed information is incorrect, please make necessary changes. 3. Sign the application and return it, along with the required fee (do not send cash), to the County Health Department. A new application is not required for next year's renewal as long as the information below remains the same.

NAME OF FACILITY _____

LOCATION _____
Street City State Zip Code

OWNER'S NAME _____

OWNER'S ADDRESS _____
Street City State Zip Code

OWNER'S PHONE _____ BUSINESS PHONE _____

Type of Food Service Establishment

	School Cafeteria		Fraternal/Civic Lounge		Detention Facility
	Hospital		Bar/Lounge		Residential Facility
	Nursing Home		Movie Theater		Other Food Service
	Child Care Center		Assisted Living Facility		Mobile Food Unit
	Limited Food Service				

COMMENTS/SPECIAL INSTRUCTIONS: _____

_____

THE ANNUAL FEE FOR YOUR FACILITY is $_____ . Please make check or money order payable to: _____ County Health Department

_____, _____, FL _____
mailing address city Zip Code

Payment must be received at the above address before _____

The undersigned owner/owner's representative, hereby agrees to operate the food establishment described in this application in accordance with the requirements of Chapter 381, Florida Statues, and Chapter 64E-11, Florida Administrative Code. The information contained in this application, which serves as the basis for licensure, is true and correct. I understand that any misrepresentation to the facts in this application, or failure to comply with sanitary standards, is grounds for denial or revocation of the sanitation certificate.

_____ _____
Signature, Owner/Owner's Representative Date

_____ _____
Signature, Environmental Health Date of Certificate

DH 4086, 7/98 (Replaces DH 4086, 12/97, Which may be used)
(Stock Number:5744-000-4086-6)